The Specialist Orthopaedic Centre

1/12 King Street Grafton NSW 2460

Title: Mr Mrs Miss Ms Other

Surname: _____ First name:_____

Date of birth: _____Home address:_____

_____

Postal address (if different) _____

Home phone number:_____Mobile number:_____

Alternative contact_____Phone_____

Email address:_____

Please inform reception of any information changes in the future

Medicare number:_____

Individual reference number:_____ Expiry date:_____

Private Health Fund – **Fund name**_____**Number**_____

Pension / Concession_____Expiry date:_____

DVA number: _____Expiry date:_____

GP / Referring Doctor:_____

Is this a workcover visit? YES NO

If so, details on separate form please, speak to reception.

Patient consent please read and sign

I give permission for my personal health information to be used for administrative purposes to assist in the running of this practice, including disclosure to others involved in my health care, such as treating doctors and specialists within and outside of this practice (this may occur through referral to other doctors and specialists, or for medical tests and in the results or reports returned to my referring doctor).

I understand that by signing below that the practice is authorized on my behalf to use my personal health information to other health care workers and I am free to withdraw consent at any time.

SIGNATURE OF PATIENT_____**Date**:_____